LOGIC.

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

The Official Journal Of The New Zealand College Of Primary Health Care Nurses, NZNO

NURSE LEAD FOOT CARE

HPV SELF SWABBING

PHC SYMPOSIUM REPORT

TEACHING DURING A PANDEMIC

WINTER 2021 EDITION

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Autumn 2021- In this issue….

Chair's Report

Celeste Gillmer
Chairperson

It is with mixed emotions that I am writing my last Chair's report for this LOGIC edition. I have accepted a position at the Ministry of Health as Principal Advisor in the COVID19 testing team and will be leaving Auckland for the next 12 months. I had to make the difficult decision that I won't be able to support the NZCPHCN as chair while in my new role and stepped down from my position in May. It was a privilege to be part of the NZ College of Primary Health Care Nurses for many years, first only as member, then on the LOGIC committee, then as publisher and finally as chair. I will continue being a member and support the College in every possible way.

Our workforce of Primary Health Care nurses across New Zealand is absolutely amazing! You carried us through COVID19 in 2020 to provide testing and care at the frontline. In 2021 you are stepping up again and provide COVID19 vaccinations to hundreds of thousands of people within a couple of months. Thank you for everything that you do, all the time that you dedicate to your community and all the sacrifices you had to make to keep New Zealand save.

I know I am leaving the College in very capable hands – Jill Clendon, as acting chair, supported by a wonderful executive committee. I would like to thank them all for their support throughout the past 18 months, when we all had conflicted priorities and their ability to stay positive was (and is) incredible. They are a very hardworking, yet small team, but strongly believe in the capability of our PHC workforce. I wish the executive committee and the 2 standing committees (Professional practice and LOGIC) all the best!

Editor's Report

Yvonne Little

Nurse Practitioner

Welcome to the first issue of LOGIC for 2021.

Saying goodbye to the dramas of 2020 felt great and I think we all believed life would get back to normal in 2021. I guess it must be the "new" normal not the "old" normal we all knew.

As health professionals our lives have gotten exponentially more frantic due to COVID- 19, and now many of us are involved with not only surveillance and tracking but also vaccinating against this virus as well as the "routine" flu vaccination rollout.

With all this going on, it's hard to see where we can find time to relax and be with friends and family. But for the sake of our own well-being, we must somehow find the time. I'm hoping that the articles in this issue may provide some relief from the daily stressors, especially the Rural Muster article by Nicky Cooper.

Despite all the obstacles put in the way of the NZCPHCN and College of Nurses Christchurch Symposium planning committee, COVID-19, Earthquakes and Tsuanami warnings – it was fantastic to see this symposium eventuate. It was great to be able to reconnect with many of our members at the Symposium in March.

We are still keen to hear from any of you who would be interested in joining our committees, as through natural attrition we have had members leave as their two-year terms have finished, also a variety of other reasons. So, if you or anyone you know would be interested then please make contact with a member of the NZCPHCN executive, professional practice or LOGIC committee.

Many people still think of this as a Practice Nurse only group, but we are definitely not that. We are keen to have more variety of nursing diversity on our committees to reflect our membership.

We had envisioned having our four issues out on time this year, but it appears we can still expect COVID-19 to interfere with our plans. Especially as our publisher is heavily involved with MIQ in Auckland and many of our committee have been heavily involved in tracking and immunising.

I would like to say thank you to the current LOGIC team for their endeavours in these trying times. So, thank you to Erica Donovan, Anne-Marie Ballagh, Lee-Anne Tait and our publisher Celeste Gillmer. A big thank you to those who have contributed to this issue as I know how precious your time is.

I hope you enjoy what we have for you in this issue and the ones to come.

Report from the Office of the Chief Nurse

Material sourced from the March 2021 update

Due to the recent departure of Margareth Broodkoorn from the position of Chief Nursing Officer and the very recently appointed new Chief Nursing Officer Lorraine Hetaraka we felt it was prudent to utilise some of the information from the recent update. We hope for the Winter issue we may have a report or at least an introduction from Lorraine, but it is necessary for her to get started in her new role before adding to her workload.

The Office of the Chief Nurse acknowledged nurses involved in testing and contact tracing, also those involved in the border and isolation/quarantine team. It was mentioned that the immunisation programme has started with lots of work by nurse leaders involved in the planning and preparation regionally of this programme of work and those involved in the initial teams. Further updates can be found here:

https://www.health.govt.nz/ourwork/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19- vaccine-updates-health-sector.

Welcome to our new Chief Nursing Officer Lorraine Hetaraka.

Lorraine Hetaraka (Tapuika, Ngāti Pikiao, Ngāiterangi, Ngāti Ranginui, Ngāti Kahu) joined the Office of the Chief Nurse as Chief Nursing Officer on 15th March 2021. Lorraine joins the team with a strong clinical and academic background in nursing leadership. Starting her career as a registered nurse, progressing into roles as a Nursing Leader and Nursing Director accountable for strategy, workforce planning, policy and primary healthcare delivery, which included working for the National Hauora Coalition, ProCare Health and Homecare Medical. Spending four years as joint Associate Director of Nursing: Māori at Auckland District Health Board and the University of Auckland and for the past year Lorraine has been the Chief Executive of Te Arawa Whānau making a significant contribution to Māori and other high needs populations wellbeing, in the communities this organisation supports. In this role Lorraine showed outstanding leadership and the ability to build collaborative relationships and networks in the health and social sector to influence positive change for the Te Arawa people. Lorraine's loss will be felt by her team at Te Arawa Whānau Ora and it will be a privilege to have her join the team.

Other Departures and Appointments in the Office of the Chief Nurse

Kathy Glasgow has left the Chief Nursing Office after 5 years, most recently as a Principal Advisor where she contributed her expertise to many areas, most particularly the Health of Older Persons. Best wishes were extended to her in her pursuit of other interests and adventures.

Jane Pryer, has been permanently appointed as Principal Advisor Infection Prevention and Control, a role which she has been assisting in since March 2020. Jane will continue to provide advice

during the pandemic and assist with the development of a National Infection Prevention and Control Strategy.

Nurse Practitioner and Enrolled Nurse – Established Programme (Supported Placements).

Part of the wider Ministry of Health funded programme to deliver a national Nurse Practitioner Training (NPTP) and to support the establishment of both NPs and ENs in primary health care and community settings, where they deliver (substantively mental health and addiction services is the The Enrolled Nurse (EN) and Nurse Practitioner (NP) Service Establishment Programme.

Funding will continue until December 2024. It is being led by the School of Nursing, University of Auckland in partnership with Mahitahi Hauora PHE; The Fono; Victoria University of Wellington; and the University of Otago. Other key partners are Te Rau Ora; Te Ao Māramatanga; NPNZ (Nurse Practitioners New Zealand); and the Enrolled Nurse Section (NZNO).

The aim is to improve access to mental health and addiction (MH&A) services in primary care and community settings by supporting for ENs (and NPs) into positions with local health providers.

Funding will target Māori, and Pacific workforce; and priority health care groups and communities. The Ministry will be involved in the ongoing governance of the programme.

E- learning Programme for Primary Health Care Nurse

The Heart Foundation is launching a new free, accessible and high-quality eLearning programme for nurses working in primary care. The new programme offers flexible eLearning for primary care nurses to assist with professional development and the renewal of Annual Practising Certificates. Each course can be applied in day-to-day practise and contribute towards professional development hours.

More information can be found at: https://www.heartfoundation.org.nz/professionals/healthprofessionals/elearning-nurses

National Measles Immunisation Campaign for 15-30 year olds

Measles is only a plane-ride away, current border restrictions will prevent the international transmission and this is an opportunity to prevent future outbreaks by acting fast and immunising now.

Because many born in the 1990s and early 2000s missed their childhood vaccinations they are at increased risk of catching and spreading measles. We need to get behind the 'Guardians of the Future' campaign to improve measles immunity in 15- 30 year olds, particularly among Māori and Pacific peoples. A hard group to reach and knowledge about measles and the harm it can cause is very low. DHBs are leading campaigns in their region to offer immunisations in places where people work, live, learn and play.

A collective effort is needed to reach these teenagers and young adults so don't let an opportunity to protect against measles go by. If someone's not sure if they've been immunised, it's okay to have it again.

Download the campaign material to share on your networks and display in your clinic via this link: https://www.hpa.org.nz/campaign/guardians-of-the-future

Website: ProtectAgainstMeasles.org.nz

Questions? Email: measles.campaign@health.govt.nz

Rural Muster

Nicky Cooper, Rural Nurse Specialist RN MSN, Murchison Health Centre

The ear plugs and St John

Having a husband that snores, I have been wearing earplugs for years, I now use 'beeswax' ones, so they don't hurt my ears, and they are a little like putting blue tac in your ears. One weekend I was the on call PRIME nurse, being the typical '  magnet' I am, I had multiple calls on one Saturday night, and was woken by either the telephone call or the pager beeping. During the Sunday in my sleep deprived state, I had noticed my hearing in my right ear wasn't quite right, which is obviously quite necessary as you examine a patient with a stethoscope at the scene of a serious medical event. The following morning at the start of work, I asked the Nurse Practitioner to have a look inside my ear before her first patient came in, but after she identified the tiny piece of ear plug, she couldn't extract it, clearly as she's not an octopus, with that her first patient arrived who just happened to be one of our towns St John volunteers, so between the two of them, with the extra pair of hands and some cunning instrument manoeuvres they managed to remove said foreign body and reinstate my hearing just in time for my first patient walking though reception.

Renal patient - sorry not sorry

I've lived in this area for 15 years now, we have had some real characters living here, both past and present, and each of them imprints on your memory. One memorable rogue was a renal diabetic, a Maori man not unlike 'Del Boy' out of 'Only fools and horses', if ever you needed something, he was your man, but probably best not to ask as most things were off the back of a lorry. He had lost his life partner to cancer a while back and had relied on her heavily, as she was his rock and without her his will to live and attempt any version of diabetes compliant care was deteriorating (the latter was never great if I'm completely honest).

His renal failure had reached the point where only Dialysis was the answer, and after much.....much discussion and coercion with him, he reluctantly agreed to go to the nearest unit 125km away. I used to do some casual shifts in their ICU, and the renal unit was alongside the ICU. I saw him arrive and acknowledged him, I also observed the staff, medical and nursing and couldn't help noticing their interactions with him. I approached one of them and decided to tell them who this belligerent uncompliant man really was, his ups and downs, this 'rough diamond' personality. I also explained what life had been like for him growing up and how as a pre-schooler he was adopted by a pakeha family in our wee little 'white' farming village, where he stood out like a sore thumb.

I called in a couple of favours with colleagues and managed to engage him in Maori health and Maori mental health support services, and he continued this line of renal treatment for 2 years.

During a remote family fishing weekend away in what I thought was a non-cell phone network area, my phone rang, and an anxious Manager informed me that he had been in the city for a week learning to be able to manage home dialysis, but that he had failed his trial. They told me he had said that was the last straw for him and that he would now go home to euthanise himself. They had begged him to let our medical personnel know and he told them, "yes you can only let Nicky Cooper know", so there I was in the middle of nowhere being asked if I could somehow help.

Having worked in both palliative and critical care I had a fair idea of how this was going to pan out, the manager expected him to last approximately 5 days only, and they desperately wanted him to re-engage in and continue his treatment.

So, 24 hrs later there I am sitting beside his bed, asking him what he wants to do, and listening to his journey, his truth, his reasons, with full sad acceptance. All he wanted was some sort of normalcy where he didn't have to drive to the city 3 times a week, where he could get back to work and go 'pig' hunting as the bush was everything to him, and it was all he had left. I told him, if this was truly what he wanted then I wanted to help him because it wasn't going to be pretty, but I was not going to watch him drown to death, and he was hesitant, and true to form, in the only way I knew him, he was going to make me work for it.

I told him, there's a reason you gave them my name, so "Stop being a dick and get in my car", and he did. We went to the local health centre and had lengthy discussions with his whanau, friends, nurse manager, and GP, we agreed to palliative support in the form of a syringe driver (locked of course) for he was a notorious for slipping the odd 'happy' pill or smoke in. We gave him an out, at every point, and when he'd heard enough, had everything he needed, he looked at me and said, you can take me home now.

He died 2 days later, during the night peacefully lying on his couch, surrounded by everyone who cared for him, having shared stories, drank some grog and smoked god only knows what, and he died in the only way I could ever truly imagine it, he did it his way, and on his terms.

I emailed the renal team shortly afterwards and told them all, and at the end of that email, I wrote, "Sorry, not sorry about the Dick comment", and I could feel him smiling with me.

The singing Butcher

I was just finishing my last appointment of the day which was a B4 school check and 4-year-old immunisations for this very robust farm boy. As they left my room, they bumped into a good friend of theirs looking a little shaken, pale, and clutching onto a bloodstained towel. The junior duty nurse also greeted me and said, that she needed me to stitch our 'needle phobic local butcher who had tried to slice and dice their thumb off.

All of us went into the consulting room, including the 4-year-old and his mother for moral support. I did an impromptu teaching session with our nurse whilst, the 4-year-old boy and mother sang Waiata's alongside the patient, which provided much comfort and hilarity. After we were all done and dusted, the boy insisted we went back to my room to get the patient a balloon, sticker, and bravery certificate just like he had got just half an hour earlier.

Education Updates:

The Arms Act 2020

There has been a lot of communication to the General Practitioners (GP) and relevant GP groups about the new obligations of health practitioners related to the Arms Act 2020. Interestingly, it appears that this information may not have been distributed to nurses and it is vitally important that we know about this also as we are health practitioners in our own right.

Therefore, if you have not been made aware of these changes to our obligations under this act, I would suggest clicking on the link below to appraise yourselves of the changes.

https://www.mahitahihauora.co.nz/uploads/Arms%20Act%201983,%20Info%20for%20Health%20Practitioners%20-%20Nov%202020%20(1).pdf

Miwa's Story – Why we need to ensure parents and teenagers have all the relevant health information about vaccinations.

Editors Note: I recently had the privilege of listening to Miwa's father Paul Chapman on a Webinar session about meningococcal disease and vaccination, speaking from a parent's perspective. The NZCPHCN had also received an email from Paul asking us how we can get the message out.

The following is their story, and I cannot stress enough the importance of NEVER assuming that they (parents/carers/teenagers/family) have been given all the information about vaccinations. At EVERY opportunity/visit we need to check in with them to find out what they know. We cannot assume that someone else has done it already. We also cannot assume that they don't want to know or can't afford vaccinations – that is THEIR decision NOT ours.

Miwa's Story – written by her father Paul Chapman

In February of last year (2020), my daughter died of Meningitis, or more specifically, Meningococcal Septicaemia. She was a 19 year old student in her second year of an Engineering Degree at the University of Canterbury.

The loss of our darling daughter, Miwa, has devastated our family, but it was terribly tragic to discover that we could have protected her if we had known that it was possible to be vaccinated against this terrible disease.

As part of dealing with my grief, and trying to make Miwa's death seem less meaningless, I contacted the RNZCGP's to see if there was anything that they could do to help raise awareness of the need to

vaccinate. Their response was incredibly supportive and through their help, the Sunday Star Times published an article about the Meningitis vaccination and again with their help, I emailed 2,468 schools to tell them Miwa's story.

I have received a number of reply emails from these schools to say that they will communicate the vaccination message to their parent communities. In several cases, the replies came from school nurses who were very kind and very proactive in their desire to help. Some of them told me how they were already actively promoting this vaccination and were proud to have achieved almost 100% vaccination for some of their Year 13 graduating students. This was wonderful news for me. However, there were some school nurses who thanked me for letting them know about this issue and explained that before receiving my email, they were not aware of the availability of the Meningitis vaccination.

That obviously concerned me and made me want to write to the National Nurses' Organisation to ask if some training could be implemented to ensure that all school nurses were aware of this issue. I therefore wrote asking for the implementation of some kind of training or communication with the members of the National Nurses' Organisation, particularly those working in schools in relation to this and see if they will become the driving force behind increasing Meningitis vaccination levels in New Zealand schools.

I appreciate that there is a cost to this vaccination. However, for some families the vaccination is free, especially those families with children living close together in places like boarding hostels or student halls of residence. In addition, I would like to think that the more widespread the vaccination becomes, the more political pressure will develop to make the vaccination free for all young people. Either way, I believe there is a need to at least make families aware and give them the choice to vaccinate.

For your information the email that I sent to the schools included some wording that a New Zealand school is already sending to their parent community. I told them they could copy the wording if it was appropriate for their school and also include the attached brochure from the Ministry of Health.

Dear Parent/Caregiver
Meningitis is a dangerous bacterial infection that can be life-threatening and deadly in just a few hours. People who survive meningococcal disease often have serious long-term effects.
The Ministry of Health recommends that young people living close together in places such as halls of residence be immunised against meningitis. Please find attached the Ministry of Health's brochure regarding meningitis and vaccines available to your child as they perhaps move on with their tertiary education and will be flatting or living in halls of residence.
Kind regards

I also told them that hard copies of the brochure are available free through the HealthEd website as follows:
https://www.healthed.govt.nz/resource/immunise-against-meningococcal-disease

Thank you for reading this. However, from the bottom of my broken heart, I would like to ask that you please take action. What has happened to my family should not be allowed to happen again.

Kind regards
Paul Chapman

Prevent Cervical Cancer! Introduce HPV Self-Testing to Aotearoa – We Need it NOW." It will save lives.

Sandra Corbett, Kaiwhakahaere

National Cervical Screening Programme

This campaign has been started because women are not being offered this more effective and safer screening test to prevent cervical cancer.
Particularly Wāhine Māori who are more than 2.5 times more likely to die of cervical cancer than non-Māori. A Human Papilloma Virus (HPV) test as a screening test is a BETTER TEST than a cervical smear. Women can do it for themselves! HPV self-testing is a game changer. The self-test has already been proven to be a very acceptable test for those wāhine under/never screened. It can be done at a clinic, at home, where-ever is best for the wāhine.

We want to see all who are eligible for cervical screening offered this better test. Cervical cancer is now preventable. We have had the HPV vaccination introduced (free for all aged 9-26 years) - the next urgent step is the introduction of HPV self–testing. HPV self-testing saves lives.

It's hard to love having a cervical smear - it's uncomfortable, it's invasive and for some there is also anxiety, whakama, mistrust and previous bad or traumatic experiences. Māori and non-Māori women will suffer unnecessary harm and death from cervical cancer unless this new HPV self-test is urgently introduced. The science is irrefutable. The current screening system is inferior, inequitable and unacceptable.

The World Health Organisation is pushing for global elimination of cervical cancer – because of the HPV test's high level of performance, countries are being encouraged to transition to HPV testing as the primary method of screening. Other countries have already switched to HPV testing as a primary test including England, Sweden, Norway, Denmark and Australia. Let's make Aotearoa New Zealand next! Our lives matter.

Me aro kī te hā o Hine–ahu-one - Pay heed to the dignity of women.

The more support we can get behind it, the better chance we have of succeeding. You can read more and sign the petition here: Please share with your networks!!

https://our.actionstation.org.nz/petitions/introduce-hpv-self-testing-to-aotearoa-new-zealand-to-prevent-cervical-cancer?share=0c3be880-3a9d-466d-9039-a3449cd6710d&source=email-share-button&utm_medium=&utm_source=email

P.S. Can you also take a moment to share the petition with others? It's really easy – all you need to do is forward this email or share this link on Facebook or Twitter:

For more information
https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/hpv-primary-screening

Nurse led footcare: Managing toenails in elderly and disabled patients.

Heather Woods is a Registered Nurse clinical nurse specialist who has been operating Mobile Foot Care Ltd for 28 years, it is a private self-funding business based in North Canterbury.

Introduction

Registered nurses as leaders in assessment and care planning are in a position to make a substantial difference to the health, wellbeing, and safety of patients. Elderly and/or disabled patients often present with foot conditions which they find difficult to manage and may initially look to primary healthcare services for information regarding how best to care for their feet. The purpose of this article is to raise awareness for registered nurses regarding the importance of foot health, and to showcase a nurse entrepreneur.

Challenges: Why foot care may be difficult to manage.

"*Foot Care is a very important part of Personal Care, especially for those who are unable to care for their own feet due to comorbidity such as diabetes, or advanced age*." (Waitemata District Health Board, 2018). Anyone who has damaged their own toe will agree, there's no doubt that foot hygiene and health is important for a sense of well-being and has a significant impact on comfort and mobility.

Research supports the fact that 80% of people over the age of 80 years find managing their nails difficult (Harvey, Frankel, Marks, Shalom, & Morgan, 1997). This may be due to poor eyesight, poor balance, reduced flexibility, arthritis obesity, shortness of breath, pain, tremor, weak hand muscles, dizziness or other chronic health conditions such as diabetes (Daly et al., 2014) or rheumatoid arthritis (Rome, Gow, Dalbeth, & Chapman, 2009).

As a result, there may be problems with the feet such as overlapping toes, tenderness, or open areas. Nails may also present problems with shape, thickness, fungal infection, or edges that are prone to in-grow. Previous injury to feet, toes, or nails can also make them difficult to manage. Nail care is an important part of personal care, and registered nurses are in a pivotal position (Daly et al., 2014; Peterson & Virden, 2013) to help meet challenges that increasing demand for assistance with personal care and support for our aging population presents (University of Auckland, 2017).

Risk related to unidentified need for assistance with foot care:

Pain: The patient may be suffering pain from long nails dragging on sheets, carpet, socks, or shoes. Long toenails may be digging into the toes in various ways. Corn or calluses may be present on the toes or soles, making each step a challenge.

Reduced mobility: this pain can result in reduced or unstable mobility, which can negatively affect quality of life, independence, exercise, concentration, demeanour, and mood.

Injury – long toenails can cut either the underside of the toe if they curl under, or the side of an adjacent toe.

Accidental injury: People can accidentally cut their toes when they are trying to cut their toenails, unfortunately these injuries can become infected, or in the case of patients with diabetes (Daly et al., 2014) extremely difficult to heal. Keller-Senn, Probst, Imhof, and Imhof (2015) note that any changes in feet, nails and skin of patients with diabetes should be assessed and treated as soon as possible. In extreme cases gangrene can become established if circulation to the feet and toes is compromised, resulting in amputations that could have been avoided.

Practicalities: What you can do to help.

There are a number of simple, practical ways to assist with foot care. Number one is regular assessment of the feet of people with diabetes (Keller-Senn et al., 2015), or patients who complain about painful feet, nails, or other related issues. This is a significantly important part of patient assessment. Nurses are then able provide these assessments and then plan care, monitoring and guidance regarding foot care. This may include advocating regular professional foot care or referral to a specialist provider.

As part of the holistic care you provide, you should often ask elderly and disabled patients

how they manage their foot and nail care, undertake a general assessment and discuss ongoing management options with them.

Process: Access to Foot Care providers:

There are a variety of foot care services in the general community, including podiatry clinics, community foot care clinics, beauty therapy clinics, and visiting registered nurses providing basic foot care in the home. Clients may need assistance from a GP or practice nurse (Keller-Senn et al., 2015) to access Podiatry services, or gain contact details for foot care services.

Procedure:

Any initial registered nurse assessment (Rome et al., 2009) of feet and nails should include, contact details, clinical history and expectations. Examine skin, feet, toes and legs for colour, oedema, inflammation, deformity, pain, evidence of disease or injury, skin integrity fragility and elasticity. Nails are examined for pain, thickness, brittleness, shape, contour, and infection. A plan of care is discussed with the client regarding the immediate needs and ongoing care of their feet and nails.

Basic foot care incudes: trimming and filing of toenails, reduction of corns and calluses, cleaning and dressing of any open areas, and sanitiser with moisturiser is applied to the feet and toes. Cream may be massaged into dry skin. Fingernails may be cut and filed at the same time that Foot Care is provided, if requested by the client and/or offered by the service provider.

Ongoing care: a follow-up appointment may be made at either a 4-6-8 or 12-week intervals, dependent upon client requirements, or a client may be directed to a Mobile Foot Care Community Clinic if they wish to explore that option.

Cost:

The cost of footcare may range from $55 to $105 per visit, or $30 at a Community Clinic.

Clients with Diabetes can access some conditional free foot care from a Podiatrist via a GP referral. WINZ may reimburse foot care costs using the Disability Allowance via receipt.

ACC: https://www.acc.co.nz/im-injured/injuries-we-cover/treatment-we-pay-for/ and Veterans Affairs: http://www.veterans.gc.ca/eng/about-us/policy/document/1239/ will provide free Foot Care with a GP referral.

Clinical Example:

Mobile community foot care clinic: Registered Nurse Primary Health Care Provider.

I am a registered nurse based in the Canterbury region. Requests for affordable foot care for people unable to travel to clinics are received from GPs, practice nurses, carers, family, and Podiatrists are made directly to me. This section describes my journey in setting up and managing 'Mobile Foot Care Ltd'.

I initially had to invest time and finances to prepare for the role by working as a Foot Care Assistant with a Podiatrist for a year. During this time, I learned basic foot care, including care of nails, corns, and calluses. The training Podiatrist was enthusiastic and supportive about a registered nurse providing a low cost, mobile, domiciliary, foot care service, because he could see the need for it and believed that Podiatrists would not be interested in providing such a service. I would refer clients needing advanced care back to him.

There is certainly benefit in a registered nurse providing this service, and combining Nursing knowledge, assessment skills and nursing philosophy within a Foot Care Service. As a registered nurse I can also assess, plan, evaluate and understand specific, unusual, or challenging needs or behaviours related to disabilities such as physical, psychiatric, neurological, sensory, intellectual disability or dementia.

At the time of my preparation, I also completed a Person-Centred Counselling Diploma at Christchurch Polytech which fine tuned my ability to listen and respond effectively during the inevitable conversations which arise during home visits (New Zealand Nursing Review, 2014). Broader health related questions often arise, providing the opportunity for health education and if required, referral to a GP or other Primary Health Service.

The home visit by a friendly, professional registered nurse is often as valued by the client as much as the foot care. Patients have reported a feeling of *total wellbeing* following the consultation, not just the fact that their feet feel much better.

Community Foot Care Clinics:

At the request of a rural GP, I established Community Foot Care Clinics in Kaiapoi, Rangiora, Pegasus, and Christchurch, which I run one day per month. In this service, which is at a minimal charge, toenails and fingernails are cut and filed, and feet receive basic foot care.

Collaborative approach:

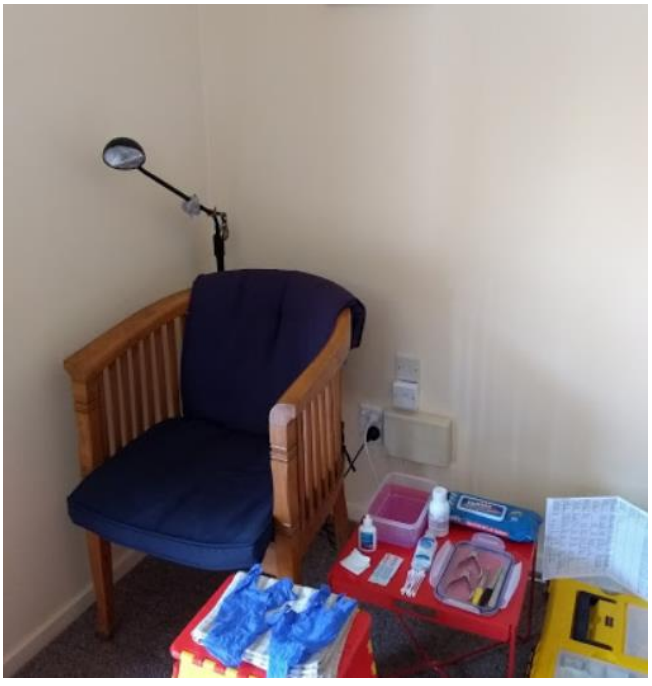
Foot care involves liaison between many health professionals. Including GP's, practice nurses, Nurse Practitioners, district nursing, hospitals, occupational health, palliative care, ACC, aged and residential care facilities, podiatrists, chemists, carers, beauty therapists, emergency care workers, diabetes centre, elderly day care centre staff, and social services. Nurses retain a pivotal role in helping to

coordinate and plan (Keller-Senn et al., 2015).

Foot care services are currently being reviewed in other regions of the country (Waitemata District Health Board, 2018), though not using Registered Nurses. However Podiatrists have recently demonstrated their support of Nurses providing Basic Foot Care by issuing a "Guide for Providers of Basic Foot Care who are not Registered Podiatrists". And more nurses are acknowledging the importance of foot care, and becoming interested in providing Foot Care.

Education for registered nurses in basic and advanced foot care:

The Ontario College of Health Studies in Canada has a well-established Foot Care Nurse System and offers online education (College of Health Studies, 2018) to registered nurses and nurse practitioners - but not worldwide currently. I am exploring options for the establishment of consistent Foot Care Education for nurses in New Zealand.



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FOOT CARE FORUM

A Foot Care Forum for Registered Nurses is going to be held in Nelson on Saturday 30th October from 8.30am to 5.30pm. The details are yet to be finalised; however, it is intended to be a day of information sharing, practical demonstration, and vigorous discussion regarding the relevance, importance, and experience of Foot Care amongst the participants, and their expectations and aspirations for the future. So please set this day aside, and await further information.

New Zealand College of Primary Health Care Nurses (NZCPHCN), NZNO and College of Nurses Aotearoa, NZ CAN (NZ) Symposium, Christchurch 6th March 2021

"Nursing Diversity brings nursing strength, a focus on Primary Health Care Nursing"

By Yvonne Little NP, Editor of LOGIC

Despite all the obstacles thrown in the way, (COVID-19 level changes, earthquakes, and tsunami warnings) the New Zealand College of Primary Health Care Nurses and the College of Nurses, Aotearoa were able to have a very successful and well attended symposium on the 6th of March 2021. Our Auckland colleagues, speakers and attendees were able to attend via video link and Webinar. With a wealth of speakers, including an international (Australian) speaker the "nursing diversity brings nursing strength, a focus on primary health care nursing" was well covered.

Starting with the Master of Ceremonies, Professor Brian Dolan OBE welcoming everyone he kept the day moving smoothly and with lots of laughter, which I think was a great stress reliever for the organising committee and all the attendees who is in these unsettling times needed a boost.

The Opening Mihi/Waiata was performed by Hector Matthews, Executive Director, Maori and Pacific Health, CDHB.

Our local speakers with their wealth of knowledge and lived experiences added to the day. It is amazing how despite working in different environments each experience resonated with the many of the attendees.

Our first Keynote Speaker was our very own Dr Jill Clendon who spoke on "Setting the scene for Primary Healthcare Nursing.

Followed by Dr Mark Jones – College of Nurses Aotearoa, NZ (via video link) who gave us an overview of the Heather Simpson Report, the impact, and opportunities for nurses in

Primary Health Care. He also discussed the Health and Disability System Review and posed a question Ambulance and Emergency Department – are they part of Primary Health Care? This is something that should be considered.

Michelle Rumsey, Director, WHO Collaborating Centre for Nursing, Midwifery and Health Development joined the symposium via video link.

This session was a real eye opener for us in New Zealand to realise not only the global shortage of nurses but the situation of our Pacific neighbours.

She discussed the state of the world nursing report – Western Pacific, which indicates a global shortage of nurses of 4.6 million, but 89% of these are in the lower to middle income countries.

Also, regulation and education in the Pacific Findings, this shows 225 health profession programmes in 32 institutes across 16 pacific countries. Unfortunately, there appears to be a general lack of continuing professional development and that these education programmes are not integrated across the Pacific or linked to our New Zealand or Australian programmes.

What if we get the wrong approach: this showed that the top-down approach for Quality Assurance Processes have the risk of alienating member countries. A future Pacific model should be based on building trust across broader pacific regions.

Included in her talk was Transdisciplinary Research which looked at the effects of climate change, disaster response and the need for improved information for policy makers and practitioners.

Michelle discussed the key findings and the Pacific Frangipani Model. Image a Frangipani flower with the following headings: 1. Building strong relationships; 2. Recognition of NDMOs Roles; 3. Clear policy direction; 4. Strong engagement of the health sector; 5. Inclusive participation.

She outlined the workforce pipeline and pathways, which is aiming to link to international standards and quality frameworks.

Following on from this she showed us the WHO Pacific Adapted – Basic Psychosocial Skills Guide for COIVD-19 responders which has 4 modules which can be accessed on youtu.be, which is designed to build resilience and mental well-being for front line health staff across the Western Pacific Region.

She concluded with discussion on the State of Worlds Nursing (SOWN) Report from the meeting held in 2019, which showed a strong case “for a decade of action to produce a marked increase in investment in nursing education, jobs and leadership as part of the global effort to achieve Sustainable Development Goals and provide universal health coverage and health for all.”

This was followed by a Panel discussion demystifying the role of the Nurse Practitioner (NP) and the collaborative approach in primary health care. They discussed their current roles and barriers for NP’s such as rejection of referrals and also the lack of support from others in their roles.

Chris Maxwell spoke on Mental Health and Residential outreach services.

When the question was posed: “How do you explain what a Nurse Practitioner does?” The answer was a simple but remarkably effective one we can all use in practice: “A Nurse Practitioner does both what a nurse and what a doctor does”.

(L-R: Christine Maxwell, NP; Jeanette Banks, RN; Jo Talarico, NP; Amelia Howard-Hill, NP)

Before lunch we had Anna Mickell from The Health Media speak on NZ Doctor, the new podcast, The Roster, The Primary Health Care Awards launched – now in its second year and He Ako Hiringa (Learning Always) which is funded by Pharmac and provides free education and free data services. You can check this out by going to www.akohiringa.co.nz

Following a lunch break where everyone got to network with colleagues from different regions of New Zealand, we reconvened to attend the breakout sessions, with a variety of subjects and speakers:

Session One

Clinical Leadership at the coalface: importance of advocacy in supporting at risk families by Anne- Marie Ballagh, RN and Nikki Beasley, RN. These ladies used real world examples of working together and not putting up barriers, prejudices and ethical issues.

Research: nursing behind the barricades: nurses experiences of working in the COVID isolation facilities by Dr Isabel Jamieson

Research: How research can shape practice to impact positively on patient outcomes by Professor Andrew Jull via video link.

Session Two

Policy: Nurses in national health policy, challenges and opportunities by Liz Manning, RN via videolink

Clinical One; Sexuality in midlife, does age have a major influence on sexuality by Dr Marie Burke.

Clinical Two: Primary Mental Health and Addiction Credential Programme by Lois Boyd, RN, MA (applied), Nag

The wrap up included an on the couch session – a potpourri of nursing diversity where 7 nurses from a variety of primary/community arenas spoke about their nursing experiences.

Suli Tuitaupe (RN) General Practice spoke on working between general practice and the Pasifika community, including working with vulnerable communities. A very engaging session who left us with a fantastic saying: “If you want to go FAST, go ALONE. If you want to go SLOW, go together.”

The organising committee – finally meeting for the first time in person on the day of the symposium. This amazing team did all the organising via ZOOM meetings.

(L- R: Amelia Howard-Hill; Erica Donovan; Marie- Lyne Bournival ; Jeanette Banks; Kelly Robertson; Bridget Wild; Nikki Beazley; Anne- Marie Ballagh)

Suli Tuitaupe (RN)

Angelina Coleman (RN) spoke on NZ Care Group Health Advisor– working with people with intellectual disabilities in the community.

(explain everything as you are doing it). (Editors note: I believe we should be doing this for every person we see in general).

Gabrielle Allen (RN) Wellington Department of Corrections spoke on supporting vulnerable population in Corrections facilities. She advised that women present as very broken due to life experiences and therefore has tried a "treat it like a spa" approach to getting women to have mammograms and cervical smears.

Overall, if you are working within this system you need to be able to understand where these women are coming from and speak their language

Deb Gillon (RN) Canterbury Clinical Network spoke on supporting older people in the community. She discussed the issue of polypharmacy and reiterated that "People have the condition of frailty", they are not frail themselves. She reminded us all that dementia is everybody's business and we need to be aware of cognitive changes in our patients so we can act early to provide support as no cure. Hearing loss is another issue for the older person, this leads to isolation and can have a cognitive effect.

Sahra Ahmed (RN) Pegasus Health spoke on Supporting health services for our refugee populations. She herself is a refugee who sought asylum in New Zealand in 1990. She trained as a nurse in Nelson. The key takeaway from her talk was: "He who has health, has hope, he who has hope, has wealth."

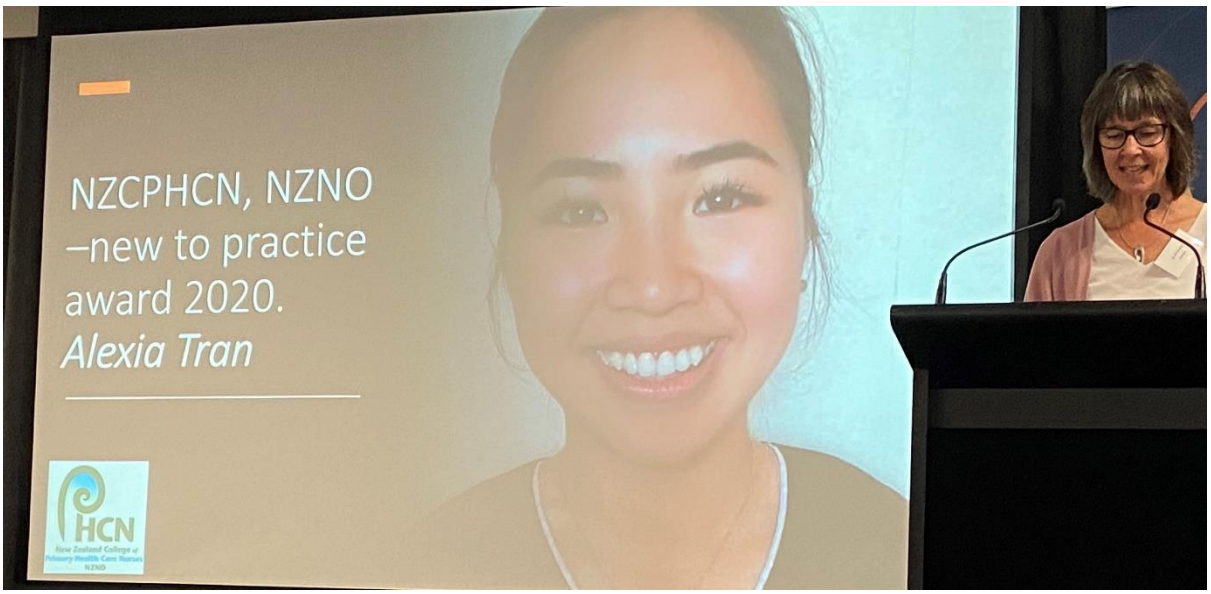
Vicky Telford (RN) Clinical Nurse Specialist, Nurse Maud Association spoke on supporting palliative care in the community. She covered the Nurse Maud service, Palliative Aged Residential Care and the reducing of admissions to Emergency Department. She also discussed the Biography Service where people record their stories.

And lastly, but certainly not least was Nicky Cooper (RN) Rural Nurse Specialist in Infant/Child/Adolescent/Parental Health. She gave us some real-life stories so I won't say too much here except to say see the Rural Muster in this and following issues of LOGIC as Nicky has kindly allowed us to print these. They are amazingly.

The day was wrapped up by the dynamic duo of Professor Brian Dolan and Dr Jill Clendon.

The organising committee was thanked, with a little extra special thank you from the NZCPHCN to Kelly Robertson, Chair of NZCPHCN Professional Practice Committee.

Dr Jill Clendon acknowledged the winner of the Nurse New to Primary Health Care Award – Alexia Tran who unfortunately could not attend as she is based in Auckland (at the time they were under Level 3 restrictions). Jill read out the supporting document that was sent in about Alexia.



We intend to have her certificate given to her by the NZCPHCN Chairperson Celeste Gillmer in Auckland with further photos and we hope to have Alexia do an article about her Award or anything else she would like to contribute to LOGIC.

The final closing was statements were given by Professor Brian Dolan and I think they are especially important to put here in LOGIC for all Nurses to read and reflect on:

“The Public look up to Doctors BUT look into the eyes of a nurse.”

“I never got rich or famous BUT I was loved, and I mattered” (to those who are important)”.

“Choose to make a difference”

Spot Prize Winners

With such a diverse group of nurses it was interesting to have these little spot prizes and find out more about how far some people travelled to get to the Symposium and how long some of us have been in the nursing workforce.

It feels like I have been nursing forever but not compared to the winner of the spot prize for “Who has been nursing the longest”. This was won by Heather Woods, Owner of Independent Mobile Foot Care Ltd in Canterbury who has been nursing since 1969.

Whilst many of us thought we had travelled some distance we were beaten to the post for this spot prize of “How came the furthest?” by Lyn Harris, Owner of Feet Retreat Ltd from Te Aroha, and RN at NZ Artificial Limb Service(NZLA) Peke Waihanga in Hamilton.

Lyn Harris and Heather Woods

Public health nurse works at the flax roots to cultivate wellbeing

By Lizzy Kepa-Henry

Her presentation to the NZNO Conference in 2020.

First Published in Kiatiaki and reprinted here with permission from the author and Kiatiaki.

My clients are your clients," said public health nurse Lizzy Kepa-Henry in her address to the conference. "But I am only one person working across two Work and Income [WINZ] sites in Porirua and Naenae, and one of only three registered nurses working in WINZ sites nationally."

In an address titled Cultivating community wellbeing at the flax roots of vulnerable and diverse communities, Kepa-Henry painted a grim picture of the realities of life for those having to survive on benefits. "In February 2020, there were 300,000 people on benefits nationally, with the Ministry of Social Development expecting this figure to rise by January next year to 495,000," she said.

Kepa-Henry described four case studies, using the names Somebody, Anybody, Who Cares and Nobody, to highlight the disparities around access to health services, to transport, to housing and education.

Somebody, she said, had had a stroke and was discharged from hospital wheelchair-bound due to obesity. There was no wheelchair access into the house nor into the bathroom. Carer input was less than an hour a day, with no occupational therapy or physiotherapy input on the discharge plan. Somebody had to move to other accommodation, with the rent rising from $110 to $540 a week in private accommodation.

Anybody sought help from emergency mental health services. After waiting two days for a reply, his phone then broke and on day-four he was told he had missed his appointment and could not be seen. After an elevation of his mood, in which he threatened violence to get the help he needed, he was arrested, then released on e-bail, and trespassed from the emergency health centre. Eventually he was prescribed twice daily medications, but he had no car and faced travel costs of $32 per day. He was eventually referred to Kepa-Henry for support.

Who Cares had been unable to fulfil his prescription. The medication cost was $85 and Who Cares only had $64 left after paying his rent. He had no car, he was not on a bus route and it was the middle of winter. "Why was there no follow-up on this client?" Kepa-Henry asked. Who Cares had a third stroke and was now being cared for full-time by his mother who had had to give up her business to do so.

Nobody had failed numerous job interview medicals and had not seen a GP for a decade. He was unwell and illiterate and had chronic abscesses on his face and upper body. After considerable advocacy by Kepa-Henry, he was eventually seen by a doctor.

"My clients don't have a standing place," she said. "They

Lizzy Kepa-Henry

Te Arawa, Ngāti Awa, Tūwharetoa, Tūhoe
Māori PG Certificate Nursing Science, Public Health Nurse
Social and Community Development

Lizzy Public Health Nurse Work and Income based role is supported by Regional Public Health, HVDHB and a contract with Ministry of Social Development.

Lizzy provides on-the-spot interventions, as a conduit service linking and supporting MSD Work and Income clients to connect with much needed health services. This work is a privileged role that allows Lizzy to navigate at flax roots and resolve vulnerable and diverse clients unmet health needs in collaboration with Work and Income Case Managers, Primary Health Care, GP's, NGO's and more.

Lizzy fulfils her nursing passion in palliative care and oncology nursing, maintaining her clinical practice through Health Care Duty Calls New Zealand Nursing Bureau.

Lizzy is passionate about the collaboration of services that navigate a way forward to improve Māori health outcomes. This work is further enhanced through Lizzy's current role as Tiamana (Chairperson) Te Upoko o te Ika a Maui – Greater Wellington Region Te Poari/Te Runanga Toputanga Tapuhi Kaitiaki Aotearoa NZNO. Lizzy also represents Te Runanga as an Executive Board member on the New Zealand College of Primary Health Care Nurses.

Lizzy believes these relationships provide and support pathways to reduce health inequalities and improved health outcomes of Māori within the Greater Wellington Region and stretching nationally. As the Greater Wellington representative, Lizzy believes all Māori Health Workforce development outcomes need to be guided, challenged, supported and well represented at local, regional, national and international levels.

Lizzy has also been a community representative on the DHB Māori Partnership Board. Lizzy played an active governance role with each DHB.

accommodation and long for a ‘forever home’. They live and survive day to day – this is their normal reality, yet they do not see themselves as vulnerable or diverse.” Kepa-Henry described her role is invisible. She called on nurses throughout New Zealand to strengthen their professional relationships and join with her in responding to clients like Somebody, Nobody, Who Cares and Anybody, “treating and caring for them with respect. He waka eke noa – we are all in this together.

https://www.yourhealthnz.co.nz/where-nursing-and-youth-unite